CODE	Section XI CLAIMS PROCESSING Standard of 95 percent relates to requirements for which sampling is appropriate. Use Worksheet: WS-CP1 and WS-CP2	YES	NO	NOTE
CP01	**The MCO assumes financial responsibility and provides reasonable reimbursement for emergency services (in and out of area) and out-of-area urgent needed services (out of area only) that its Medicare enrollees obtain outside the MCO, even without prior authorization.** **42 CFR 417.414(c)** **[ ] MET [ ] NOT MET**			
MOE	❑ Determine if the MCO makes accurate determinations of emergency/out-of-area urgent needed services, covered benefits, and clean/non-clean claims so that they are appropriately pended. *Social Security Act*, § 1842(c)(2)(B) and § 1816(c)(2)(B) (**Definition**: A "*clean*" claim is a claim that has no defect or impropriety, including lack of required substantiating documentation for non-contracting providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim. (§1842(c)(2)(B)) of the *Social Security Act*. A claim is clean even though the MCO refers it to a medical specialist within the MCO for examination. If additional documentation (e.g., the medical record) involves a source outside the MCO, the claim is not considered "clean".)			
CP02	**The MCO pays 95 percent of "clean" claims from unaffiliated providers and suppliers within 30 days of receipt. When clean claims are paid in over 30 days, interest is computed and paid.** **Appropriation Bill, October 1992, P.L. 102-394; Sections 1876(g)(6)(A), 1842(c)(2) and 1816(c)(2) of the Social Security Act, and Section 9311 of OBRA 1986.** **[ ] MET [ ] NOT MET**			
MOE	If payment is not made on a clean claim from an unaffiliated provider within 30 days, interest should be paid at the rate used for purposes of section 3902(a) of Title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made. The rate is approved by the Secretary of the Treasury and is published in the *Federal Register* twice each year.			
CP02a	**If the MCO delegates claims processing to contracting medical groups, IPAs, or other entities, these entities pay 95 percent of clean claims from unaffiliated providers and suppliers within 30 days of receipt. When clean claims are paid in over 30 days, interest is computed and paid.** **Appropriation Bill, October 1992, P.L. 102-394; Sections 1876 (g)(6)(A), 1842(c)(2) and 1816(c)(2) of the Social Security Act, and Section 9311 of OBRA 1986.** **[ ] MET [ ] NOT MET [ ] N/A**			

MOE	**<u>Note To Reviewer Regarding Application Claims Payment-Related Elements to Cost Contracts</u>**: For element CP02, please note that the requirements of the Act at section 1876(g)(6)(A) specify that a risk-sharing (and not cost-based) contract require the eligible organization to provide prompt payment of claims submitted for services and supplies furnished to individuals pursuant to such contract if the services or supplies are not furnished under a contract between the organization and the provider or supplier. If payment is not made consistent with section 1862(c)(2)(A), interest must be paid to the applicable provider and / or supplier at the rate used for purposes of section 3902(a) of Title 31. The statute is silent on whether cost-based contractors must likewise pay clean claims within 30 days. In reality, unaffiliated providers and suppliers providing Medicare-covered services to beneficiaries in cost-based health plans customarily submit claims for payment directly to the Medicare carrier or fiscal intermediary processing claims under Medicare fee-for-service as opposed to submitting claims to an enrollee's Medicare cost-contracting health plan. Carriers and fiscal intermediaries are governed by statutory requirements at section 1842(c)(2) and 1816(c)(2) that require timely claims payment, payment of interest, etc. In instances where nonaffiliated providers submit claims to cost-based contractors, Article IV.J.5 of the 1876 cost-based contract between HCFA and a cost-based contractor specifies a general condition that the contractor provide prompt payment consistent with the provisions of section 1816(c)(2) and 1842(c)(2)) of all claims submitted for services provided and supplies furnished to individuals pursuant to the contract if the services or supplies are not furnished under a contract between the organization and the provider or supplier. Therefore, CP02 applies to cost-based contractors.			
CP03	**The MCO (including its contracted providers) makes an organization determination within 60 days from receipt of claims (from both affiliated and unaffiliated providers). If the MCO makes a determination that is wholly or only partially adverse to the enrollee, it notifies the enrollee of its determination (denial) within 60 days from receipt of the claim. To make organization determinations timely, 95 percent of claims are processed within 60 days from date of receipt.** **42 CFR 417.608(a) [ ] MET [ ] NOT MET**			
CP03a	**If the MCO delegates making and processing organization determinations to contracted medical groups, IPAs, or other entity, the determinations are made within 60 days from receipt of claims (from both affiliated and unaffliated providers and suppliers). If the MCOs delegates making a determination that is wholly or only partially adverse to the enrollee, the delegated entity notifies the enrollee of the determination (denial) within 60 days from receipt of the claim. To make organization determinations timely, 95 percent of claims are processed within 60 days from date of receipt. (Cross-reference any findings to AM02a)** **42 CFR 417.608(a) [ ] MET [ ] NOT MET [ ] N/A**			
CP04	**The MCO notifies the enrollee of his/her right to appeal if the MCO has failed to make a determination (adverse) within 60 days of receipt of the claim (i.e., failure to provide notice is deemed an adverse organization determination subject to appeal). 42 CFR 417.608 (c) [ ] MET [ ] NOT MET**			

MOE	❑ Determine whether the MCO and/or its contracting providers control, process, and pay claims consistent with statutory requirements (30 and 60-day standards). ❑ Assess the adequacy of the MCO's claims processing system. It should identify and track all claims and include the following types of information: ❑ provider and amount billed; ❑ date the claim was received; ❑ date additional development was initiated; ❑ date claim was adjudicated; ❑ amount paid; ❑ date check written and mailed; ❑ reason for denial, if applicable; ❑ procedures for claims transferred from carrier or fiscal intermediary (they should be treated like any other incoming claim). Procedures should specify time frames for: ❑ making determination of "clean" or "non-clean" within specific number of days of receipt; ❑ initiating development of non-clean claims within specific number of days; ❑ following up on pending claims within specific number of days of original request for additional information with subsequent requests at specified intervals; ❑ making an organization determination to pay or deny; ❑ sending notice with appeal rights to the enrollee if an organization determination is not made within 60 days of receipt (claim is deemed a denial, subject to appeal). ❑ Generate claims reports to determine processing times. Can reports be generated on a periodic basis (for example, monthly) that reflect claims payment and denial data? ❑ Observe claims work flow - from receipt in the mail room to distribution to the claims department and mailing of notices and checks. **Review/ Determine**: ❑ MCO's oversight of its contracting groups. Are its providers aware of claims processing requirements? Are the MCO's claims processing procedures written and available to staff? ❑ The MCO and/or its contracting providers correctly identify "clean" claims. ❑ MCO's written instructions to ensure that the definition of "clean" claims is consistent with HCFA's definition, and a sample of paid claims from unaffiliated providers to determine processing times. ❑ The MCO and/or its contracting providers accurately process claims for covered services, including emergency and urgently needed out-of-area care, and point-of-service (POS) related claims. ❑ MCO's written instructions to ensure the definitions of "emergency" and "urgently needed out-of-area" care are consistent with the regulations (e.g., no prior authorization is required). ❑ Claim denials to ensure that Medicare-covered services and other benefits outlined in the MCO's evidence of coverage (EOC) (including services delivered pursuant to any POS benefit) are not inappropriately denied.

MOE contd.	❑ Processed claims to ensure that only appropriate co-payments are billed the enrollee. ❑ If the MCO offers a point-of-service (POS) benefit, review the MCO's written procedures for assuring that proper coverage decisions and appropriate payments are made for non-contracted providers and suppliers providing services by way of the MCO's POS benefit. Review any claims processing procedures specific to processing POS claims. In making determinations, include an assessment of the MCO's contracting providers (to assure covered services are provided by IPA/medical group's network of specialists and other health care providers). Is the oversight adequate so that the MCO/contracting providers meet the requirements? Coordinate the claims review with the *Appeals review in Section XII* to determine whether the MCO meets the 60-day time frame for notifying the enrollee of adverse organization determinations. (**NOTE:** Some States have claims processing time frames that MCOs are expected to meet. It is helpful to know what the State's requirements are and whether the State monitors the MCO based on these requirements.)			
CP05	**The MCO has procedures to identify payers which are primary to Medicare, determine the amounts payable, and coordinate benefits. HCFA may not reimburse an organization for services to the extent that Medicare is not the primary payer.)** **§1862(b) of the Social Security Act, 42 CFR 417.528(d)(2) and (3), and HMO Manual §6105.1; 2170.2** **[ ] MET [ ] NOT MET**			
MOE	Determine whether the MCO has written procedures to ensure that claims involving coordination of benefits (State or Federal workers compensation, EGHP, automobile medical, no-fault insurance, other liability, and self-insured MCO) are identified. **Review:** Procedures to determine: ❑ Who processes secondary payer issues. ❑ How secondary payer issues are identified. ❑ How identified cases are communicated to the department that processes these cases. ❑ Whether the MCO's system flags claims when Medicare is secondary. ❑ If recoveries are accounted for in the ACR calculation. **Interview:** MCO Coordination of Benefits (COB) and financial staff.			
COST REPORTING AND PAYMENT FOR COST-BASED CONTRACTORS ONLY				
CP06	**The MCO has procedures which detect and record duplicate payments for Part B services, and retrieve such payments from physicians, suppliers, or enrollees. HMO Manual §6105 [ ] MET [ ] NOT MET**			
CP07	**If the MCO elects to pay its providers directly, it makes proper coverage decisions and appropriate payments for services, in accordance with §421.100 and §421.200.** **42 CFR 417.532(e)(2); OPL 96.043 [ ] MET [ ] NOT MET**			

MOE	**Review:** MCO's written procedures for identifying, recording, and recovering duplicate payments: ❏ How does the MCO identify claims for services obtained from non-contracting providers for whom no authorization was given? ❏ Are Explanations of Medicare Benefits/Carrier Payment reports used as a basis to identify possible duplicate payment? ❏ What department(s) is (are) responsible and what coordination are necessary? ❏ Letters to providers requesting recovery of payments. ❏ MCO's written procedures for assuring that proper coverage decisions and appropriate payments are made. ❏ What department is responsible? ❏ Have any improper decisions been made? If so, then review documentation requesting providers to repay. **Interview:** MCO's staff responsible for these activities (e.g., MIS, accounting/finance).